

**PATIENT APPROVAL FOR
RELEASE OF MEDICAL INFORMATION
Jefferson County Fire Protection District No. 4
Brinnon Fire Department**

I do hereby request and authorize Jefferson County Fire District No. 4 to release a copy of any and all medical records maintained by Jefferson County Fire District No. 4 regarding: _____ to me.
(Patient's full name)

I further request and authorize Jefferson County Fire District No. 4 to release a copy of any and all of my medical records to: _____.
(Designee's name) (Relationship to patient)

Patient identification data.

Name: _____

Address: _____

Phone: _____

Birth date: _____ Social Security No.: _____

Date(s) of emergency medical service care provided by Jefferson County Fire District No. 4 personnel: _____

Signature of patient whose records are being released *Date*

Signature of witness to patient's signature *Date*

If request is handled via mail, patient's signature must be notarized.

State of Washington)
)ss.
County of Jefferson)

I certify that I know or have satisfactory evident that _____ is the person who appeared before me, and said person acknowledged that he/she signed this instrument as a free and voluntary act for the uses and purposes mentioned in this instrument.

Dated this _____ day of _____, 20____.

(print name)

Notary public in and for the State of Washington,
residing at _____.

My appointment expires _____.

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Brinnon Fire Department